MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08875

CERTIFICATE OF DEATH

08873

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Snow Hill
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Snow Hill 23-1
d. STREET ADDRESS: Route I, Box 303
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: W. — Last: Blake

4. DATE OF DEATH: Month: June — Day: 23 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: Negro

MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 23 1891

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Irvin Ayres

14. MOTHER'S MAIDEN NAME: Rosie Purnell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Lottie Fleming — Address: 718 Girard St. Havre De Grace Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Hours
DUE TO (b): Hypertensive Heart — 8 Yrs.
DUE TO (c): disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May, 1967, to Jne, 1967 that (I) (we) last saw the deceased alive on Jne 20 1967, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: David Rafat — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/26/67

22c. PHYSICIAN'S NAME (Type): DAVID RAFAT

22d. ADDRESS: Snow Hill Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-27-67

23c. NAME OF CEMETERY OR CREMATORY: Mt. Wesley Cem.

23d. LOCATION (City or Town) (County) (State): Snow Hill Wor. Md.

24. FUNERAL DIRECTOR: Samuel Long — ADDRESS: New Church, Va.

25a. REC'D BY REGISTRAR DATE: JUN 28 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Complete Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08876

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08875

1. PLACE OF DEATH
a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City
c. LENGTH OF STAY IN 1b 3 HOURS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hastings Hotel

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
d. STREET ADDRESS 315 Maryland Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Charlotte Middle: May Last: Carmean
4. DATE OF DEATH Month: June Day: 25 Year: 1967
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 9/30/92
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager
10b. KIND OF BUSINESS OR INDUSTRY: Nursing Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Handy Shockley
14. MOTHER'S MAIDEN NAME: Mary Shockley
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give war or dates of service) WW I
16. SOCIAL SECURITY NO. 200-26-2077
17. INFORMANT: W H Carmean (Son) Address: St Paul Minn.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion, Acute — INTERVAL BETWEEN ONSET AND DEATH: (INSTANT)
DUE TO
(b): ASCVD, Myocardial Insuff. — 2 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE H J Townsend Jr M.D.
EXAMINER'S NAME (Type) H J Townsend, Jr
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, City, town, or county) Ocean City, Md
22. DATE SIGNED June 25 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 6/28/1967
23c. NAME OF CEMETERY OR CREMATORY: Forest Lawn Cem
23d. LOCATION (City or Town) (County) (State): Morganza Pa

24. FUNERAL DIRECTOR: Gerald C. Saunders ADDRESS: Snow Hill Md.
25a. FILED BY (REGISTRAR) DATE: JUN 28 1967
25b. REGISTRAR'S SIGNATURE

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon sheets. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08877

CERTIFICATE OF DEATH

08876

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
c. LENGTH OF STAY IN 1b: 1 week.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): BERLIN NURSING HOME

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WOR.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEWARK 21/
d. STREET ADDRESS: RFD
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First GEORGE — Middle SAMUEL — Last CROPPER

4. DATE OF DEATH: Month JUNE — Day 16 — Year 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: JAN. 14, 1893

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: LUMBERMAN

11. BIRTHPLACE (County & State, or foreign country): NEWARK WORC. MD

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: SEWELL CROPPER

14. MOTHER'S MAIDEN NAME: SARAH ELLA TOWNSEND

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 220-01-9665

17. INFORMANT: H. GEORGE S. CROPPER — Address: LAUREL MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral apoplexy
DUE TO (b): Hypertension
DUE TO (c): Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
443

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6-1-67 19__ to 6-16-67 19__, that (I) (we) last saw the deceased alive on 6-15 1967 and that death occurred at 1:00 AM, from causes and on the date stated above.

22a. SIGNATURE: Clifford E. Schatt
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Clifford E. Schatt M.D.

22d. ADDRESS: Berlin, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 6 | 18 | 67

23c. NAME OF CEMETERY OR CREMATORY: BUCKINGHAM

23d. LOCATION (City or Town) (County) (State): BERLIN WOR. MD

24. FUNERAL DIRECTOR: Amasa A. Burbage — **ADDRESS**: Berlin Md

25a. REC'D BY REGISTRAR: JUN 20 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08878

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08877

1. **PLACE OF DEATH**
   a. COUNTY: Worcester — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Whaleyville
   c. LENGTH OF STAY IN 1b: 25 years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R-2

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Md — b. COUNTY: WOR
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Whaleyville 23.1
   d. STREET ADDRESS: R2
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First: FLORENCE — Middle: P — Last: DUNCAN

4. **DATE OF DEATH**: Month: JUNE — Day: 25 — Year: 1967

5. SEX: F

6. COLOR OR RACE: N

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8a. DATE OF BIRTH: Dec 25 1893

9. AGE (In years last birthday): 73 yrs.

IF UNDER 1 YEAR: Months: ___ Days: ___ IF UNDER 24 HRS.: Hours: ___ Min: ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ___

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Price

14. MOTHER'S MAIDEN NAME: Mary Collins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 214-32-5877

17. INFORMANT: Jessie Price — Address: 1504 Old Mill Rd R-5 Salisbury, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): ASCVD — INTERVAL BETWEEN ONSET AND DEATH: 5 years.
   DUE TO (b): ___
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): ___
   4221

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Anorexia.

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [X] Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: F S Townsend Jr. M.D.

EXAMINER'S NAME (Type): F S Townsend, Jr.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, City, Town or County): Ocean City, Md

22. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/28/67

23c. NAME OF CEMETERY OR CREMATORY: Pullets Chapel Cem.

23d. LOCATION (City or Town): Whaleyville (County): ___ (State): Md.

24. FUNERAL DIRECTOR: Peter Whaley — ADDRESS: Whaleyville, Md.

25a. REC'D BY REGISTRAR — DATE: JUN 27 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film 6390 7/20/67 kk

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08873 08878

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH — a. COUNTY: Worcester Co. Ocean City MARYLAND; b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OCEAN CITY, MARYLAND; c. LENGTH OF STAY IN 1b: HOURS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DEERS HEAD.

2. USUAL RESIDENCE (Where deceased lived at institution: Residence before admission) — a. STATE: Md. b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington Md. 1502
d. STREET ADDRESS: 3129 University Blvd. e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Patrick Middle Edward Last Flynn
4. DATE OF DEATH: Month 6 Day 17 Year 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 19- 1944
9. AGE (In years last birthday): 23 22 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ins. Salesman (Student Uni. of Md.,)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): 3405 Sheperd St. Chevy Chase Md.,
12. CITIZEN OF WHAT COUNTRY? Montgomery

13. FATHER'S NAME: Hugh P. Flynn
14. MOTHER'S MAIDEN NAME: Ella Roche

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ANTERIOR FRACTURE DISLOCATION CERVICAL CORD - SUBARACHNOID HEMORRHAGE.
DUE TO (b): CONTUSION INJURY
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: INSTANTANEOUS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) PEDESTRIAN INJURY
20c. TIME OF INJURY Month, Day, Year: Hour 2 o.m. p.m. 6/17 1967
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) OCEAN CITY (County) WORCESTER (State) MD.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Robert F. Kapelow Jr M.D.
EXAMINER'S NAME (Type): ROBERT F. KAPELOW JR
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED: 6/16/67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 6/21/67
23c. NAME OF CEMETERY OR CREMATORY: GATE OF HEAVEN
23d. LOCATION (City or Town) WHEATON (County) (State) MD.

24. FUNERAL DIRECTOR: HARLON FUNERAL HOME - WASH. D.C. ADDRESS
25a. RECD BY REGISTRAR DATE JUN 30 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DECEASED'S PHYSICIAN: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08880 — 08879

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

1. PLACE OF DEATH — a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Pocomoke
c. LENGTH OF STAY In Ib
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) — a. STATE: Md. — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Pocomoke
d. STREET ADDRESS: R.F.D. 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Daniel — Middle — Last: Gumby
4. DATE OF DEATH: Month: June — Day: 8 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug. 3, 1895
9. AGE (In years last birthday): 71 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William H. Gumby
14. MOTHER'S MAIDEN NAME: Georgiana Ginn
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 219-03-3935
17. INFORMANT: Elizabeth Hall — Address: 409 Roundview Rd. Balto., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Probable acute Myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: 2 hours
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c): Arteriosclerotic Heart Disease — 4 yrs.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): alcoholism -
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: David Rafat M.D
EXAMINER'S NAME (Type): DAVID RAFAT
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street city town or county)
22. DATE SIGNED: 6/8/67

23a. BURIAL CREMATION REMOVAL (Specify): Burial
23b. DATE THEREOF: 6-12-67
23c. NAME OF CEMETERY OR CREMATORY: Hall's Hill Cem.
23d. LOCATION (City or Town) (County) (State): Pocomoke Wor. Md.
24. FUNERAL DIRECTOR: Samuel Lewis
ADDRESS: NewChurch, Va.
25a. FILED BY REGISTRAR DATE: JUN 14 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5)
6M 1/67

1

FOR STATE HEALTH DEPT. W

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2t,9,1h & 16 Film #3330 6/27/67 pc

38881 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 08880

1 PLACE OF DEATH
a. COUNTY Worcester — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City
c LENGTH OF STAY IN 1b
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ocean At 100th St (APPROX.)

2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a STATE West Virginia — b. COUNTY Berkley
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Martinsburg
d STREET ADDRESS RFD 1
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First: LARRY Middle: Leo Last: Hess
4 DATE OF DEATH Month: 6 Day: 24 Year: 1967
5 SEX M
6 COLOR OR RACE W
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH 9/15/45
9 AGE (In years last birthday) 21 yrs
If UNDER 1 YEAR: Months / Days — If UNDER 24 HRS: Hours / Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (State or foreign country) Martinsburg W.V.
12 CITIZEN OF WHAT COUNTRY? USA
13 FATHER'S NAME Kelly Hess
14 MOTHER'S MAIDEN NAME Curtis Curtiss Batts
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)
16 SOCIAL SECURITY NO 233-70-2076
17. INFORMANT Brother, Baltimore, Md. Address 336 Phila Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Drowning — INTERVAL BETWEEN ONSET AND DEATH 10 minutes
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
9278

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☒ CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Swimming in Ocean
20c TIME OF INJURY Month, Day, Year Hour a.m. 2 p.m. 6/24/1967
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Ocean
20f (City or town) Ocean City (County) Wor (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐, and in my opinion death resulted from. Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE F.J. Townsend M.D
EXAMINER'S NAME (Type) F.J. Townsend, JR
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, City, Town, or County) Ocean City Md Wor
22. DATE SIGNED JUNE 25, 1967

23a BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 6/27/67
23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran
23d LOCATION (City or Town) Ardein (County) Berkley (State) W.Va.

24. FUNERAL DIRECTOR James A. Bradshaw ADDRESS Berlin Md
25a RECD BY REGISTRAR DATE JUN 27 1967
25b. REGISTRAR'S SIGNATURE Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08882

CERTIFICATE OF DEATH

08881

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Elnora — Middle: T. — Last: Pusey

4. DATE OF DEATH: Month: June — Day: 2 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4/15/80

9. AGE (In years last birthday): 87 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Pocomoke, Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James Tull

14. MOTHER'S MAIDEN NAME: Ida Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): --------

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Mrs. Francis Leake, Snow Hill, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute Pulmonary Edema & Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 2days
DUE TO
(b): Hypertensive Cardiovascular Renal disease — 10 yrs
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
442X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Osteoporosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June, 1950, to June 2, 1967, that (I) (we) last saw the deceased alive on May 28 1967, and that death occurred at 4 A M, from causes and on the date stated above.

22a. SIGNATURE: Robert La Mar, M.D. — M.D — ATTENDING PHYS ☒ — MED DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 6-3-67

22c. PHYSICIAN'S NAME (Type): Robert C. La Mar, M.D.

22d. ADDRESS: 104 Bay St Snow Hill, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/6/67

23c. NAME OF CEMETERY OR CREMATORY: Christian Cemetery

23d. LOCATION (City or Town) (County) (State): Snow Hill, Maryland

24. FUNERAL DIRECTOR: Thomas E. Gleason

ADDRESS: Snow Hill, Maryland

25a. RECD BY REGISTRAR DATE: JUN 6 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit file pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08883

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item #3, Film 5X-11/2/67-mnb

C8882

1 PLACE OF DEATH
a. COUNTY WORCESTER. MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) BERLIN.
c LENGTH OF STAY IN 1b 1 DAY.
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CASTAWAY TRAILER PARK.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a STATE MARYLAND b COUNTY WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN, MD.
d STREET ADDRESS
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First CHARLES Middle (CHARLIE) Last QUILLIN

4 DATE OF DEATH Month 6 Day 27 Year 1967

5 SEX M

6. COLOR OR RACE W

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 4- 1911

9. AGE (In years last birthday) 56 yrs

IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life even if ret red) MANAGER

10b KIND OF BUSINESS OR INDUSTRY Grocery Hardware

11 BIRTHPLACE (State or foreign country) Worcester Co. BERLIN MD

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME MILBORN QUILLEN

14 MOTHER'S MAIDEN NAME VICTORIA BRITTINGHAM

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO NO

16 SOC. A. SECURITY NO 220-16-7687

17 INFORMANT Address MRS CHARLIE QUILLEN BERLIN MD RD

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT. 4201.
DUE TO (b) ARTERIOSCLEROTIC VASCULAR DISEASE
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH YEARS

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month Day, Year Hour a.m. p.m.

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE R.F. Kaplowitz MD

EXAMINER'S NAME (Type) R.F. KAPLOWITZ

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town or county)

22. DATE SIGNED 6/27/67

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

23b DATE THEREOF 6/30/67

23c NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL

23d LOCATION (City or Town) (County) (State) BERLIN WOR. MD.

24 FUNERAL DIRECTOR Anna A. Burbage

ADDRESS Berlin Md

25a RECD BY REGISTRAR DATE JUN 30 1967

25b REGISTRAR'S SIGNATURE J. Charles Judge

VR A15ME (5) 6M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME (5) 6M 7/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08884

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C8883

PLACE OF DEATH
a COUNTY: Worcester — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Whaleyville
c LENGTH OF STAY IN 1b: Lifetime
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): —

2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a STATE: Md — b COUNTY: Wor.
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Whaleyville
d STREET ADDRESS: —
e RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Ralph — Middle: H. — Last: Smack
4 DATE OF DEATH: Month: June — Day: 4 — Year: 1967
5 SEX: M
6 COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: June 20, 1895
9. AGE (In years last birthday): 71 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b KIND OF BUSINESS OR INDUSTRY: Farmer
11 BIRTHPLACE (State or foreign country): Whaleyville, Md
12 CITIZEN OF WHAT COUNTRY?: USA
13 FATHER'S NAME: James Smack
14 MOTHER'S MAIDEN NAME: Sara E. Davis
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16 SOCIAL SECURITY NO: 215-12-6802
17 INFORMANT: Lillie Nock (Niece) — Address: Whaleyville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Burns 4° Total body — INTERVAL BETWEEN ONSET AND DEATH: INSTANT
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PROBABLE OR CONTRIBUTING CAUSE OF DEATH ☐
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of item 18): Burned to death in fire in home.
20c TIME OF INJURY (Month, Day, Year, Hour a.m. p.m.): 4 p.m. June 4 1967
20d INJURY OCCURRED White at work ☐ Not White at work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f (City or town) (County) (State): Whaleyville, Md.

21 **I certify** that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☐, Accident ☒ Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: F J Townsend Jr M.D
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): F J Townsend JR (M.D.) — Address (Street, City, Town, County): Berlin, Md Wor. Co.
22. DATE SIGNED: June 6, 67.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 6/7/67
23c NAME OF CEMETERY OR CREMATORY: Dale
23d LOCATION (City or Town) (County) (State): Whaleyville Md

24 FUNERAL DIRECTOR — ADDRESS: Peter Whaley Selbyville, Del.
25a RECD BY REGISTRAR DATE: JUN 9 1967
25b REGISTRAR'S SIGNATURE: J Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

38885 — C8384

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Pocomoke City
c. LENGTH OF STAY IN 1b: 25 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 506 4th Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City
d. STREET ADDRESS: 506 4th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LILLIE — Middle FLORENCE — Last TAYLOR

4. DATE OF DEATH: Month June — Day 25 — Year 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 22, 1881

9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (County & State, or foreign country): Accomack County, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William T. Bloxom

14. MOTHER'S MAIDEN NAME: Nancy Dix

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): --

16. SOCIAL SECURITY NO.: 216-54-9087

17. INFORMANT — Address: Miss Blanche Taylor, Pocomoke, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Disease — INTERVAL BETWEEN ONSET AND DEATH: Instant
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Gall Bladder trouble — 20 years
DUE TO (c): Gastric Indigestion — 30 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Refused B & Preston

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2Da. ACCIDENT ☐ WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____, 19__, to June 25 1967, that (I) (we) last saw the deceased alive on ____ 19__, and that death occurred at ____ M. from the causes and on the date stated above.

22a. SIGNATURE: N. E. Sartorius, Sr. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): N. E. SARTORIUS, SR.

22d. ADDRESS: Pocomoke City, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-27-1967

23c. NAME OF CEMETERY OR CREMATORY: Downing Cemetery

23d. LOCATION (City, town or county) (State): Oak Hall, Virginia

24. FUNERAL DIRECTOR: Robert H. Watson
Robert H. Watson

ADDRESS: Pocomoke City, Md.

25a. REC'D BY REGISTRAR DATE: JUN 29 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08886 Item #1d Film #G3401 6/29/67 DC 08885

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 204 William Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
d. STREET ADDRESS: WILLIAMS ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDNA Middle EARL Last VENABLE

4. DATE OF DEATH: Month June Day 18 Year 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: APRIL 23, 1875

9. AGE (In years last birthday): 92 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: RET

11. BIRTHPLACE (County & State, or foreign country): DUDLEY S.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: WILLIAM B. MASSEY

14. MOTHER'S MAIDEN NAME: NAOMI FUNDERBURKE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 213-42-1196

17. INFORMANT: WILLIAM W. VENABLE Address: BERLIN MD

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Apoplexy
DUE TO (b): Hypertension
DUE TO (c): Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 6-1-67, 19.., to 6-18-67, 19.., that (I) (we) last saw the deceased alive on 6-17-67, and that death occurred at 12:.. M, from the causes and on the date stated above.

22a. SIGNATURE: Clifford E. Schott M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Clifford E. Schott M.D.

22d. ADDRESS: Berlin Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 6/20/67

23c. NAME OF CEMETERY OR CREMATORY: EVERGREEN

23d. LOCATION (City, town or county) (State): BERLIN WOR. MD

24 FUNERAL DIRECTOR'S SIGNATURE: Anna A. Burbage

ADDRESS: Berlin Md

25a. REC'D BY REGISTRAR DATE: JUN 22 1967

25b. REGISTRAR'S SIGNATURE: Charles Yeager

Items 18&21 Film 390 6-29-67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08887 08886

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Worcester — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ocean City
   c. LENGTH OF STAY IN 1b: 1 day
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): China Seas Motel - 57th St

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Pennsylvania
   b. COUNTY: [redacted] Philadelphia
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): [redacted] Philadelphia, PA. 7538
   d. STREET ADDRESS: 6701 Oxford Ave
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George — Middle Ziegelmair — Last
4. DATE OF DEATH: Month June — Day 25 — Year 1967
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 02-22-1911
9. AGE (In years last birthday): 56 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CONTRACTOR
10b. KIND OF BUSINESS OR INDUSTRY: Building
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: John Ziegelmair
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Mrs Geo. Ziegelmair Phila Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Pending Autopsy — INTERVAL BETWEEN ONSET AND DEATH:
   DUE TO (b): Coronary occlusion acute — Instant
   DUE TO (c): ASCVD — 3 years (approx)
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   4201
   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: F J Townsend M.D.
EXAMINER'S NAME (Type): F J Townsend, Jr
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town or county): Ocean City, Md
22. DATE SIGNED: June 25, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 6/29/67
23c. NAME OF CEMETERY OR CREMATORY: Hillside
23d. LOCATION (City or Town) (County) (State): Roslyn Montgomery PA.

24. FUNERAL DIRECTOR — ADDRESS: Anna A. Burbage Berlin Md.
25a. REC'D BY REGISTRAR — DATE: JUN 27 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15ME (5) 6M 1/66